DOCUMENT RESUME

ED 189 803 EC 124 534

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TITLE The Transdisciplinary Model: An Alternative Approach for Meeting the Needs of Children in Early Childhood Education Programs for the Handicapped.
INSTITUTION New Mexico State Univ., Las Cruces.
PUB DATE [80]
NOTE 14p.

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Disabilities: *Educational Needs: *Health Needs: Individual Needs: *Interdisciplinary Approach: Models: Needs: Preschool Education: Services: *Teamwork: Young Children
IDENTIFIERS *Transdisciplinary Approach

ABSTRACT

The paper discusses the transdisciplinary model, an alternative approach for meeting the needs of children in early education programs for the handicapped. A brief review of the interdisciplinary and multidisciplinary approaches to providing services for such children is provided, and the limitations of the two approaches are examined. The transdisciplinary approach is an attempt to meet the needs of the child by breaking the traditional rigidity of discipline boundaries and by avoiding compartmentalization and fragmentation of programs and services. It is a direct attempt to consolidate medical and educational models of service through coherent programing and consistent handling of the plan by everyone involved so that the educational and therapeutic impact is sustained and a developmental approach prevails. Not only is the individualized developmental plan for the child designed by the transdisciplinary team, but it is implemented by the team as well. A rationale for the appropriateness of this approach with infants and other young handicapped children emphasizes the need for fewer people working directly with the child, continuity of programing, consistency of services in the home and school situation, and the importance of parent participation. However, the question of degree of handicap and the ability of a team member to train a primary therapist to treat a severely handicapped child who requires very specialized treatment remain critical issues. (DLS)

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The Transdisciplinary Model: An Alternative Approach for Meeting the Needs of Children in Early Childhood Education Programs for the Handicapped

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The authors would like to express their sincere appreciation to Dr. Margie Kitano for her editorial assistance in the preparation of the original manuscript.

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During the past decade, the fundamental view of the handicapped child as a citizen with rights has emerged. Current Federal legislation (e.g., P. L. 94-142, as complimented by Section 504 of The Vocational Rehabilitation Act of 1973) requires that related services such as audiology, occupational therapy and speech therapy be made available in addition to specially designed instructional programs. Indeed, as noted by Sirvis and Edgar (1978), in order for there to be appropriate educational programming and maximum skill development, input from a variety of disciplines is crucial. To date however, the development and implementation of team strategies which maximize communication among teachers, parents and related service disciplines in special education programs has been very much overlooked. Programs which rely upon team input have most frequently employed either an interdisciplinary or multidisciplinary approach despite frequent documentation concerning the limitations of these two models (e.g., Sherr, 1977; Sirvis, 1978). Although research data are presently sparse, it appears that a viable alternative to the interdisciplinary and multidisciplinary models--particularly in infant and other early childhood programs for handicapped children--is the more recently developed transdisciplinary model.

The present work has the following two-fold purpose: (a) to provide a brief review of the interdisciplinary and multidisciplinary approaches

and (b) to examine the use of the transdisciplinary model as a viable alternative.

The Multidisciplinary Approach: Description and Limitations

The multidisciplinary model evolved from the medical model in which data are gathered by individuals from various areas of expertise and reported to a single designated person. In current early childhood special education programs, the multidisciplinary model is primarily used for initial assessment purposes. However, although attempts have been made to deal with the child as a whole, the data often remain fragmented (Mendelson, 1967; Sherr, 1977). As Hart (1977) has described it, "each professional has viewed the child in the light of a particular discipline and has made recommendations accordingly. Thus a medical, audiological, psychological, and educational report may be sent to a . . . teacher without a group decision being made regarding the best procedure to be followed with the child" (p. 392).

It is important to note here that, since assessment can be defined as "the critical observation and analysis of behavior from which treatment needs are determined and the procedures and goals are determined" (Banus, 1971, p. 31), it is essential that assessment be a team effort calling on and using the expertise of many professionals (Haring, Hayden, & Beck, 1976). As Hobbs (1975) has pointed out, screening and assessment processes are virtually meaningless endeavors unless there are adequate services provided for the children involved. It follows that services can by no means be regarded as adequate unless there is coordination in the recommendations for programming. This is particularly the case with multiply handicapped

infants and preschoolers where scant and perhaps opposing recommendations may negate the effects of treatment and hold a child back needlessly during his most critical and malleable years (White, 1971).

The Interdisciplinary Model: Description and Limitations

To avoid shortcomings of the multidisciplinary model such as fragmentation of data, the interdisciplinary model has been adopted by many programs. In this approach, the child is evaluated by team members independently and recommendations for programming are made by group consensus. Unfortunately, as described by Hart (1977), these recommendations may not consider the actual resources available since implementation is frequently dismissed as not part of the team's responsibility. Responsibility for implementation of recommended programs then falls to the classroom teacher who often lacks administrative authority to carry them out. Often, fragmentation of services results since the tendency of related service personnel is to work independently of one another. For example, speech therapists frequently have little or no direct contact in working situations with classroom teachers or parents and therefore, neither are able to follow-up or continue the program since they are unaware of the special techniques used. Thus, a young handicapped child could miss out on additional services at a most critical time in his life.

An additional problem related to the interdisciplinary approach (with special regard to the young handicapped child) has been that of the large number of professional contacts that the child must endure. Erikson (1963) has described the importance of the facilitation of a trusting relationship. Williamson (1978) has emphasized that this trusting relationship is

best achieved with young children through the involvement of one, or at most two, practitioners. This factor has influenced the recent movement toward more exchange of knowledge and function between disciplines and the search for a more workable approach to teaming. Research has also demonstrated the possible negative significance of too many people working with the very young child, particularly at the infant level (Moore & Moore, 1972).

The Transdisciplinary Model: An Alternative Approach

The transdisciplinary approach is an attempt to meet the needs of the child by breaking the traditional rigidity of discipline boundaries (Sirvis, 1978) and by avoiding compartmentalization and fragmentation of programs and services (Sherr, 1977). The transdisciplinary approach is a direct attempt to consolidate medical and educational models of service through coherent programming and consistent handling of the plan by everyone involved so that "the educational and therapeutic impact is sustained and a developmental approach prevails" (United Cerebral Palsy Association, 1976, p. 2).

The interdisciplinary team members form the basis of the transdisciplinary approach. The team collaborates to design an individualized developmental plan for the handicapped child. Information is gathered from parent interviews, case histories, reports from others who have served the child, and from interdisciplinary assessment. Up to this stage the transdisciplinary approach is very similar to the interdisciplinary approach. However, from this point on it radically departs from the other teaming methods since not only is the plan designed by the team, but it is

implemented by team effort through the unique element of "role-release."

Role-release effectively reduces the number of professionals needed to render separate direct services to the child. It is, by consensus, an authorization for one particular person to act as primary therapist and to represent multiple disciplines in the delivery of services. The ability to act in this capacity is obtained via systematic teaching-learning experiences that cross disciplinary boundaries. In some instances, special education and/or related service roles are released to parents. In Project AIDE (1978), for example, parents of high-risk infants are trained as their childrens' primary therapists by such professionals as physical therapists, teachers, and occupational therapists. This approach holds particular promise in rural-remote areas where it is not always feasible for children to attend a center-based program on a regular basis.

Services in the transdisciplinary approach are thus delivered without excessive or inconsistent handling by a variety of persons as is evident in the multidisciplinary and interdisciplinary approaches. Also, since fewer people are directly involved with any one child, the facilitation of a trusting relationship is enhanced. This factor is particularly crucial with the infant or very young child (Erikson, 1963). From another standpoint, current financial and professional manpower limitations (Abbott & Sabatino, 1974) lend support to consideration of the transdisciplinary approach as a viable alternative. As emphasized by Stainback, Stainback, and Maurer (1976), it may not be feasible to expect one person to possess all the expertise required to facilitate the development of a multiply handicapped child. Yet, this expertise can be obtained to a large extent

through the process of role-release in the transdisciplinary model, thereby making it an appealing alternative for budget-conscious administrators.

Discussion

In summary, implementation of a transdisciplinary approach to teaming in EC-H programs may serve to overcome problems (e.g., lack of ongoing contact among professionals) which, frequently, have been identified with the more traditional interdisciplinary and multidisciplinary models. In the authors' view, however, a number of important implications of the transdisciplinary approach have not yet been examined carefully. Several sources (e.g., Hart, 1977; United Cerebral Palsy Association, 1976) have stated that the team member who trains the teacher/parent is accountable for what happens to the children. At no stage is accountability relinquished. However, it must be recognized that since the transdisciplinary approach has not been adopted in many special education programs to date, the concept of accountability has rarely been put to the test in that context. Licensing laws must be considered as another relatively "unknown area." It may be feasible to limit liability if the primary therapist were to obtain a "written prescription" from team members, attach it to the child's IEP, and use it under team supervision. Clearly, further information/data is needed at this time regarding the aspects of accountability and liability in programs employing this approach.

Additional research is also needed regarding the types of program for which the transdisciplinary approach is most suitable. A rationale has been presented for the appropriateness of this approach with infants and

other young handicapped children, with emphasis placed upon (a) the need for fewer people working directly with the child, (b) continuity of programming, (c) consistency of services in the home and school situation, and (d) the importance of parent participation. However, the question of degree of handicap and the ability of a team member to train a primary therapist to treat a severely handicapped child who requires very specialized treatment remains an issue. In particular, applied research needs to be carried out in this area. Types of program must also be examined (e.g., is the transdisciplinary approach most successful in a center-based program, in a home-based program, or in a home-center-based program?). In short, longitudinal and short-term comparative studies are needed to determine the efficacy of this promising model.

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